2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: September 6, 2011 LOCATION: City of Berkeley, CA

Participants

02	Consumers/Family Members/Consumer Advocates
05	Providers
08	County Representatives
05	Other
03	Phone Participants
23	**Total Participants**

Pre-Meeting Education Session- Questions/Comments

- How can we be assured that counties spend the MHSA funding as mandated in Prop 63? The Conference Committee set up services for the sub-division of CSD. Housing Subdivision was given more responsibility for MHSA services.
- Consumers do not have money for computers to print/access information about the process and background documents. DMH attempted to make all of the meetings as accessible as possible. Consumers can also ask their Local Boards/Commissions to support their participation.

Background and Context Questions/Comments

- Is the DHCS Deputy Director position definite? Yes, it was created as a result of AB102 and AB106.
- Are you going to discuss other mental health divisions? What about the [new] Department of State Hospitals? What about forensics programs? There will be a state department (to be named later) to administer/oversee state hospitals with that singular focus.
- Will the Office of Multicultural Services stay intact? If that is what the stakeholders ask for, that is what will happen.
- If functions go to the counties, will the money/resources go with them? Realignment (AB100) directed $861m to counties for EPSDT and Managed Care. AB3632 moved to CDE.
- With all of the responsibilities coming to the local level, will there be enough money that follows? Specifically for AB3632, etc. Negotiation of budget/resource allocation is happening at the Legislature, Department of Finance, and the Governor's level. The Governor is pursuing revenue increases, but nothing has passed yet.
- San Francisco clients are concerned that when this transition happens we need to take the best practices, especially recovery principles; and, Medi-Cal billing codes need to go over too, to ensure consistency in billing, etc. DHCS negotiated getting mental health staff to go with the functions. They need people who have the expertise.
- DHCS has [historically] been responsible for health services. We want to make sure that the mental health functions don't get lost. We don't want to go back to the medical model. We spent years fighting for the recovery model.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- What will happen with the currently scheduled audits? Will there be a new surge of audits that changes the schedule? They are preparing for this huge transition. The official merger happens on September 1st. DHCS is looking at the current audits and assessing what should happen with those. The Program Compliance staff (from DMH) is going over to DHCS.
- What about MHSA audits? Tell us what you think, where should it go? But, we don't do "audits" of MHSA programs. We [previously] did plan reviews and expenditure/fiscal reviews.
- Is there a plan to train DHCS staff in the recovery model? Why are some of the cuts not happening at DHCS to ensure a more balanced staff for health and mental health? Where is the mental health expertise going to come from, especially since so many jobs were lost at DMH? Those jobs were not "lost". Many of the staff positions were transferred to DHCS. Others were placed in other state departments.

Based upon today's presentation, what are the changes in mental health at the state level that stand out for you?

- What stands out is what is not being said regarding the implementation of the MHSA. Where is the "fix"? When will the conversation about the two tier system be addressed?
- Will the commitment to MHSA transformation/principles still be there? What about the state oversight to ensure local commitment to these principles? What is the role of the MHSOAC? Counties have been implementing MHSA programs for six years. They meet regularly with stakeholders, Boards and Commissions, and Boards of Supervisors; they have built in checks and balances.
- How can we really address mental health when everything is now about Medi-Cal? MHSA programs are not going away; the counties will just have more local control.
- What about the Department of Alcohol and Drug Programs? AB106 moves the Drug Medi-Cal functions to DHCS.
- How will dually-diagnosed people be addressed? You tell us, in small group break-outs.
- Who is the oversight body to ensure that counties are appropriately implementing MHSA programs? Not just for the reversion. What happens to plan approval at the state level? What is the future process? The state doesn't currently have authority for plan approval.

What opportunities do you see as a result of the transition at the state level?

Providers/Consumers/Family Members/Consumer Advocates

- DMH can teach DHCS expertise related to getting away from the medical model.
- Less bureaucracy
- Learn from consumers; change from the ground up
- Streamline billing and documentation system
- Disallowances for Medi-Cal
- Un-silo funding; streamline the process

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- Concerned about losing services; will new Medi-Cal services help to restore funding for services?
- I am concerned about the due process measures that will be put in place for clients and family members.
- The client and family member voice needs to be built into the mental health system regardless of who "takes over"
- Voice of cultural competence for Native American communities for community defined practices
- We need to remember individuals that we are serving; keep them from falling through the cracks.

County Representatives

- I am concerned about resources.
- I am concerned about the status of the Department of Rehabilitation cooperatives
- Opportunity to join the national effort on health care reform and other changes happening at the federal level.
- Overall, how much money is the state losing vs. how much money is coming to the local level? How much is lost? Not sure that any funds will be lost; it will be distributed on a more regular basis but without the state in the "middle".
- How are the allocations determined? AB100 defines the allocation formula.
- There is no accountability with this new structure to ensure that money goes to what it is supposed to go to (MHSA). There are other checks and balances at the local level, the MHSA still has oversight of PEI and Innovation.
- Some federal opportunities have been lost due to leadership at DMH. For example, EBP for Cooperative Employment developed by Dartmouth is looking for state partners.
- Take a look at and audit the cooperative programs that are out there. CalMHSA wants to take on more responsibility for statewide projects; consider CalMHSA as an option. Alameda County has not chosen to be a part of CalMHSA at this time. Another proposal is to create a joint department combining alcohol & drug programs and mental health services (possibility a state Department of Behavioral Health Services, to be named later)
- Employment services, peer support, etc. are not currently reimbursable under Medi-Cal.
- Opportunity for jurisdictions to invest in community defined practices.
- Concerned about going back toward a medical model.
- Opportunity to address specific community needs.
- Opportunity to address co-occurring disorders.
- Improve efforts toward integration, person with multiple needs so that you can address all of those needs. It would be wise for California to follow the lead with federal health care reform. Aside from concerns about the medical model, we should integrate with physical health. We also need same day billing.
- Physical health and mental health integration (co-location)
- We need to focus on older adults
- Integrated funding/services especially related to AOD services (multiple funding streams). We need it at the state level; we don't know what will happen with federal health care reform.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- Opportunity to focus on integration/co-occurring disorders and "fuse it all together". It needs to be under DHCS to align with federal effort but there needs to be stand-alone leadership (Deputies) with expertise in AOD and MH.
- Can't forget about persistently SMI population, no day programs for those individuals
- On-going auditing for outcomes, performance measure, on-going goals. We need to continue to make sure that we are giving the best services to people. I am concerned about the loss of oversight. We need to identify what is working well and stick with it.
- Who will be monitoring implementation of plans to ensure adherence to the plan? Issue resolution track- what is the state function involved in that? It is helpful to have a non-city/county option. The MHSOAC and the CMHPC are still options for issue resolution.
- The functions need to naturally fall into the scope of the other functions at the agency, align with similar functions.

Which entity should assume responsibility for the functions/programs listed? What functions/programs are missing from the list?

Providers/Consumers/Family Members/Community Advocates

- For program oversight, we need to get oversight at the front end
- I want oversight of the money, but fear that if it is DHCS it will only be a medical model agency
- Issue resolution needs to be with a separate entity, independent from county and state. Use best practices from other states (Massachusetts). Who has the "teeth" to make things happen? We need to clarify the process and make decisions based on resolution.
- FSP data does not give information on the system of care; only a small percentage of consumers is involved in data collection
- Data does not capture the quality of services. We need to improve the quality of data, what gets captured, not just reflective of the number of people in the door.
- Housing decisions should be based on the Senate Office report and follow the recommendations in the report
- The state needs to keep responsibility for co-occurring disorders; to get it started we need to use best practices; remove barriers regarding effectiveness

County Representatives and Providers

- EQRO is a great venue; but they weren't very substantial. It's something that should be reviewed/evaluated to make it more robust. DHCS is looking at the federal requirements for EQRO. Some people are champions of EQRO, others are not. EQRO currently scheduled to go to DHCS. They are looking at the review cycle- is one year ok? Should it be a three year cycle? How do consumers get involved in the EQRO process? How do we get information? NAMI CA, Network, Pool of Consumer Champions, etc. That should be an open process, not just selected people.
- Everyone has to spend so much time with data to justify services for financial oversight purposes and this leaves less time for actual services.
- Financial oversight should go with the other functions to DHCS.
- What about CalMHSA? Over 40 counties have joined to date.

- Is it a certainty that DMH/ADP will go to DHCS? It is a certainty that Medi-Cal will go over to DHCS. The non Medi-Cal functions are what this process will determine.
- As these organizations take on more responsibility, they are going to have to re-organize to provide adequate oversight. Along with that, people will need resources.
- DMH has enough understanding of operations (specific details/knowledge of program approach) but CalMHSA might be better at the statewide financial functions of the programs.
- What is included in the Housing functions? It is strictly financing through CalHFA.
- The state needs to have some oversight of housing. Without the state, folks would be underserved. But there should be increased local control.
- There needs to be local input into programs, counties are so different.
- I can see CRC's getting lost at the local level due to lack of prioritization of the program.
- Decisions about CRC's have to be made locally, but DMH needs to be the promoter.
- Combining ADP and DMH in a unified approach would help with SAMHSA (etc.)
- The CMHPC is involved in all of these functions, but they only meet quarterly.
- Veteran's services should have some state oversight. It should go under a joint DMH/ADP agency. Better linkage with non-profits that serve veterans.
- Coordination of county disaster response could happen at CIMH.
- How could locals be responsible for monitoring of compliance/quality improvement/program evaluation when it is the local programs that are being evaluated? Locals are required to have a program evaluation component in their contracts.
- Contract funds for Cooperatives (DoR) went unspent because counties didn't know how to access the funds. Locals need to work with ADP/DMH and CalMHSA (and CIMH) to promote these programs.
- There has to be better coordination about what is available through SAMHSA.
- PATH and Housing should go to the same place.
- CA is really behind in CIT.

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

- The funding issue; resources are limited. We need to look more at natural/community supports (like faith centers, etc.). The State shouldn't be responsible for meeting <u>all</u> of the needs.
- There is still, despite MHSA, a discrepancy in services that needs to be addressed.
- Orient local jurisdictions to the changes. Have a media campaign and concrete technical assistance to help local stakeholders.
- Looking at the cultural competency piece of MHSA, you need buy-in. We need to keep people accountable.
- Accountability is very important. Who is doing this? Who is in charge?
- Making sure that there is advocacy for cultural competence. We don't have enough information about the history/functions (especially the Office of Multicultural Services).

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- We need to ensure that the merging of ADP and DMH [into DHCS] is about integration not cohabitation. We need goals, detailed assessments, and outcomes measures. There will be differential philosophies and we need to overcome that by identifying common goals.
- We need an improved Ombudsman Office.
- There is a push and pull between locals and the State. In some counties, the local county is the best place. In others, the State is best. The State needs "teeth" to provide technical assistance to struggling counties.
- We need to go back and look at programs that have been lost, or not implemented as they were indicated in the planning phase. There is a risk of that happening without program oversight.
- Oversight at the state level to ensure that people get services, not screened out because they don't have Medi-Cal. Make sure that people get the help that they need.

Phone Participants

- We need to look at cultural needs overall and expand accountability about how we invite stakeholders to the process. Make sure folks are really getting to the table.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.